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ALERTS

Provider Funding Under The CARES Act: What Strings Are Attached?

April 21, 2020

The recently passed CARES Act provided $100 billion in relief funds to hospitals and other healthcare providers impacted by the COVID-19 pandemic. From these funds, the Department of Health and Human Services (HHS) began distributing $30 billion in direct payments to eligible Medicare providers on or around April 10 intended to reimburse providers for healthcare-related expenses and lost revenue attributable to the pandemic.

The CARES Act Provider Relief Fund Payment Attestation Portal is open for the use of providers who have been allocated a payment from the initial $30 billion general distribution.

Providers are required to attest that they will abide by the terms and conditions of the payment within 30 days of receipt of payment. If a provider receives payment and cannot comply or does not wish to comply with the terms and conditions, the provider must contact HHS to remit the full payment.

These HHS disbursements are direct payments based on services previously rendered to Medicare beneficiaries; they are not loans and do not need to be repaid. Providers must be eligible for payment and must comply with the payment terms and conditions to prevent recoupment.

While the funds will be deposited automatically to all providers reimbursed under the fee-for-service (FFS) payment model that was established in 2019, payment is conditional on the healthcare provider's acceptance of designated terms and conditions.

Under those terms and conditions, to accept the payment:

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- Providers must diagnose, test or care for individuals with actual or suspected cases of COVID-19
- Providers must use the funds for expenses undertaken to treat COVID-19 or to cover losses due to COVID-19. As HHS is primarily interested in keeping providers afloat through the pandemic, the department will broadly view every patient as a possible case of COVID-19.
- To use the funds deposited, providers must not be subject to exclusion from the Medicare program, or have had their billing privileges revoked
- Providers must comply with recordkeeping and recording provisions of the CARES Act and other federal legislation
- Providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient greater than what the patient would have otherwise been required to pay if an in-network provider had provided the care
- If a provider has received more than $150,000, the provider must submit detailed report to HHS and the Pandemic Response Accountability Committee, including the total amount of funds received, a list of projects and activities funded by the distribution, and other documentation under the CARES Act, the Federal Funding Accountability and Transparency Act of 2006, and 45 CFR Section 75.302 and 45 CFR Sections 75.361 through 75.365.
- The provider must supply other information required by future program instructions or requested by the HHS secretary, the inspector general, or the Pandemic Response Accountability Committee to substantiate the reimbursement of costs under this award

To obtain more information regarding this alert, contact the Barnes & Thornburg attorney with whom you work or Michael Grubbs at 312-231-7224 or michael.grubbs@btlaw.com.